Hawaii Employer-Union Health Benefits Trust Fund
CONFIRMATION NOTICE - Open Enrollment Print Date: 05/22/2003

DOE, John
1234 Honolulu Street
Honolulu, HI 96000

Employee ID: HB00000
Date of Birth:
Agency/Dept:
Bargaining Unit:
Warrant Dist:
Event Date: 07/01/2003

Please review your Benefit Plan enrollments and other information on this confirmation notice. If you find any errors, please make the necessary corrections, sign and date the form and return it to your Departmental Personnel Officer or designee immediately for processing and routing to the EUTF.

If there are no corrections, keep this form with your important family records.

YOUR BENEFIT PLAN ENROLLMENTS

Benefit Plan	Benefit Plan Carrier	Coverage Type	Effective Date	Pay Period Deductions	State PCP?
Medical/Drug/Chiro	HMSA/HMSA/Mutual Benefits	Family	07/01/2003	$ 138.93	YES
Dental	Hawaii Dental Service	Family	07/01/2003	$ 9.63	YES
Vision	Vision Service Plan	Family	07/01/2003	$ 2.53	YES
Life	Aetna Inc.		07/01/2003	None	
Total Deductions - Per Pay Period				$ 151.09	

ENROLLED DEPENDENTS	Birthdate	Relationship	Gender	Medical/ Drug/Chiro	Dental	Vision
DOE, Jane	11/01/1950	Spouse	Female	Yes	Yes	Yes
DOE, Charles	11/02/1980	Son	Male	Yes	Yes	Yes
DOE, Sally	11/03/1985	Daughter	Female	Yes	Yes	Yes

Please make the above corrections to my Benefit Plan Open Enrollment information.

Signature: _____ **Date:** __/__/____